Mr. WRIGHT (in reply) said that he had used this type of electrode in a considerable number of cases, and, so far, without any fatality; he was pleased with the results he had obtained. Radium was not possessed by his hospital, and getting radio-active tubes was expensive; at present he was using diathermy in association with other things, such as Souttar's tubes. If one could get through the stricture at all, it was easy, with this type of terminal, to feel the lower end of it and pass it through. Then if the current were turned on and steady traction maintained, the sharp knife-edge would cut through. It was easy to perceive when one had finished the application, and the instrument could be employed without running unjustifiable risk. It was a great help to use a large tube, and to stop when one had cut through the stricture. In the earlier types he found that the heat of the terminal damaged the bougie, and the makers of this instrument had inserted a disc of a material which would stand the heat. It could be made more rigid, but he did not require it to be so. It had been kept small, and there was quite a light cable.

Nasal Polypus showing the Structure of a Glioma, from a Patient suffering from Cerebral Tumour.

(Specimen and Lantern Slides.)

Shown by DOUGLAS GUTHRIE, M.D.

CLINICALLY, the growth appeared to be the ordinary type of nasal polypus and only on microscopic examination was its real nature revealed. The patient, a well-built man, aged 46, previously healthy, was struck by a falling beam of wood in 1911 and sustained slight concussion. Next year, there gradually appeared paralysis of the right arm and leg, and this has persisted. There was also slight facial paresis. Headache has been present and has sometimes been severe, but vomiting has only occasionally been noted. The Wassermann reaction was negative, and potassium iodide, given for a long time, had no effect. No optic neuritis. The condition was diagnosed by a neurologist as glioma of the left frontal lobe of the brain.

In 1920 he became unconscious and remained so for five days, but gradually recovered. His mental outlook was altered and he became childish and emotional. In 1920, and again in 1921, a polypus was removed from the left nasal cavity. In 1925, symptoms of left nasal obstruction reappeared, and the observer removed with Luc's forceps a growth the size of a hen's egg, which burst and discharged serous fluid during removal. It appeared to originate above the attachment of the middle turbinal. Subsequent history was uneventful. Microscopic examination shows the typical appearance of a glioma, the free surface being covered by ciliated epithelium. The interior of the growth is œdematous, and the centre is excavated by a large cyst. At several points small hæmorrhages have occurred.

The two curious features of the case were the intranasal extension of a glioma of the brain and the fact that no meningitis had followed its removal. The patient was not only relieved of nasal obstruction, but of the headache which made his life a misery. The diagnosis hinged entirely upon microscopic findings, as shown by a series of photomicrographs to illustrate the typical "glia" cells, of tapering shape and with the nucleus at one end. Those were well seen in all the sections.

Sir JAMES DUNDAS-GRANT said he had recently had a case which illustrated a point in connexion with this specimen, namely, one in which there was a sarcoma extending from the ethmoid region into the brain. There were also polypoid growths into the nose; these he removed time after time, and could get no evidence of malignancy in them. The present case showed the need for caution in assuming that there was no malignancy in these conditions. Grünwald had emphasized that in malignant disease of the sinuses there might be ordinary polypoid and inflammatory outgrowths into the nose which showed no signs of malignancy.

Dr. DOUGLAS GUTHRIE also showed slides from a fatal case of rapidly-growing glioma of the frontal lobe, under the care of Dr. Norman Dott, in which there was found on post-mortem examination a downward extension of the tumour into the ethmoidal region, causing a deep depression, but no perforation, of the cribriform plate.

[Notes of the cases, with illustrations, will be published in the *Journal of Laryngology*.]

Swelling in the Pharynx.

By N. E. KENDALL, F.R.C.S.Ed.

GIRL, aged 21. Swelling on lateral pharyngeal wall on the left side, which extends into the naso-pharynx and down to just above the arytænoids. First seen ten months ago. No pain, no difficulty in swallowing and no perceptible change in size. Suggestions as to diagnosis and treatment.

Discussion.—Mr. T. B. LAYTON said he did not suppose any Member would know what was the nature of this swelling until it had been cut out. He suggested that it might be a parotid tumour arising from a salivary or other gland in the lateral wall of the pharynx. He had seen one case beneath the tonsil, and another in the soft palate. Apparently it was non-malignant, and it was tense and elastic. He recommended that it be attacked *via* the mouth, under intra-tracheal anæsthesia; he expected it would shell out with fair ease, though there was a possibility of the capsule bursting in the process.

Sir JAMES DUNDAS-GRANT said he thought this must be a malignant growth, probably sarcoma. There was a discrete enlarged lymphatic gland behind the angle of the jaw, which was disconnected from the parotid gland, and it was a question whether this ought not to be removed for microscopical examination, or whether radium might be tried.

Mr. NORMAN PATTERSON said he considered that the swelling in the pharynx and that in the neck were one and the same thing, and he would be inclined to attack it from the outside, whatever its nature.

Mr. F. H. DIGGLE suggested that this tumour be left alone. The patient had noticed it five years ago, when she had her tonsils removed, and it was only recently noticed by her doctor, when she had a sore throat. His own view was that it was a lipoma. A number of these cases were seen in which the lateral wall of the pharynx was displaced inwards.

Dr. DOUGLAS GUTHRIE said that still another possibility in diagnosis was the rare tumour originating from that tiny ductless gland—the carotid body.[1] He had seen one case which closely resembled that shown at present; it could be distinguished from the commoner mixed tumour of this region only by microscopic examination. Growth was very slow in his (the speaker's) case; the tumour had hardly altered since coming under notice three years ago, and caused the patient little inconvenience.

[1] *Journ. Laryng. and Otol.*, 1924, xxxix, p. 635.